United States of America
Railroad Retirement Board

Form approved
OMB No. 3220-0034

Statement Of Authority To Act For Employee

It is not necessary to complete this form for an employee who can sign papers or can sign by mark and understands transactions relating to his or her sickness benefits.

Instructions

1. Complete Section 1 and have the employee's medical doctor complete Section 2. If you are not related to the employee by blood or marriage, state your relationship and why no relative is acting for him or her. For example, an employee's union representative might explain: "I am his union chairman. He has no immediate family."
2. Complete this statement by following the instructions in the UB-11 booklet under "Instructions for Completing Forms, Statement of Authority to Act for Employee (SI-10)." Signing this statement gives you the authority to sign any claim forms on behalf of the employee. When signing claim forms use your full name, and beneath your signature, write "On behalf of" and the employee's full name.
3. Return this form with the next application or claim form you file with the RRB.

Section 1 Statement of Individual Acting for Employee

It is my belief that _____ _____
(Employee's Name) (Social Security Number)

whose address is _____
(Employee's Address)

is at this time incapable of signing forms in connection with obtaining sickness benefits under the Railroad Unemployment Insurance Act; of transacting the necessary business relative to his or her application and claims for such benefits; and of applying the proceeds of any sickness benefit payments.

I believe the employee to be incapable because _____

_____
(Briefly describe employee's condition)

My relationship to the employee is _____

I affirm that, in the transaction of business relating to the application and claims of this employee, including the use of any benefit payments, I will act on behalf of and in the best interest of the employee. I will promptly notify the RRB at such time as this employee's condition changes so that I need no longer act for him or her. I understand that criminal and civil penalties may be imposed on me for providing false, incomplete, or fraudulent statements, or for withholding information to cause the payment of benefits. I certify that, to the best of my knowledge, the information I have provided is true, complete, and correct.

Name (please print)	Signature			Phone Number ( )
Street Address (please print)	City	State	ZIP Code	Date

Section 2 Statement of Employee's Doctor

I have examined the employee named above and find that he/she is incapable of signing forms and transacting business relative to his/her claims for sickness benefits under the Railroad Unemployment Insurance Act.

Name of Doctor (please print)	Signature of Doctor			
Office Street Address (please print)	City	State	ZIP Code	Date
Tax Identification Number				